

1 KAMALA D. HARRIS
Attorney General of California
2 ALFREDO TERRAZAS
Senior Assistant Attorney General
3 JANICE K. LACHMAN
Supervising Deputy Attorney General
4 State Bar No. 186131
1300 I Street, Suite 125
5 P.O. Box 944255
Sacramento, CA 94244-2550
6 Telephone: (916) 445-7384
Facsimile: (916) 327-8643
7 *Attorneys for Complainant*

8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. **2012-3**

12 **STEVEN WADE SWIHART**
105 Brookestone Court
13 Headland, AL 36345

A C C U S A T I O N

14 **Registered Nurse License No. 727110**

15 Respondent.

16
17 Louise R. Bailey, M.Ed., RN ("Complainant") alleges:

18 **PARTIES**

19 1. Complainant brings this Accusation solely in her official capacity as the Executive
20 Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

21 2. On or about May 28, 2008, the Board issued Registered Nurse License
22 Number 727110 to Steven Wade Swihart ("Respondent"). The license was in full force and effect
23 at all times relevant to the charges brought herein and will expire on November 30, 2011, unless
24 renewed.

25 ///

26 ///

27 ///

28 ///

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
84

2
3
4
5

6
7
8
9

10

11

12

13

14
15
16

17
18

19
.20

23

22
23

24
23
20

2

2

1 (b) Use any controlled substance as defined in Division 10 (commencing
2 with Section 11000) of the Health and Safety Code, or any dangerous drug or
3 dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or
4 in a manner dangerous or injurious to himself or herself, any other person, or the
5 public or to the extent that such use impairs his or her ability to conduct with safety to
6 the public the practice authorized by his or her license.

7 (c) Be convicted of a criminal offense involving the prescription,
8 consumption, or self-administration of any of the substances described in
9 subdivisions (a) and (b) of this section, or the possession of, or falsification of a
10 record pertaining to, the substances described in subdivision (a) of this section, in
11 which event the record of the conviction is conclusive evidence thereof.

12 (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible
13 entries in any hospital, patient, or other record pertaining to the substances described
14 in subdivision (a) of this section.

15 7. Code section 498 states:

16 A board may revoke, suspend, or otherwise restrict a license on the ground
17 that the licensee secured the license by fraud, deceit, or knowing misrepresentation of
18 a material fact or by knowingly omitting to state a material fact.

19 COST RECOVERY

20 8. Code section 125.3 provides, in pertinent part, that the Board may request the
21 administrative law judge to direct a licensee found to have committed a violation or violations of
22 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
23 enforcement of the case.

24 DRUGS

25 9. "Morphine" is a Schedule II controlled substance as designated by Health and Safety
26 Code section 11055(b)(1)(M).

27 10. "Dilaudid," a brand of Hydromorphone, is a Schedule II controlled substance as
28 designated by Health and Safety Code section 11055(b)(1)(K).

11 11. "Ativan," a brand of Lorazepam, is a Schedule IV controlled substance as designated
12 by Health and Safety Code section 11057(d)(13).

13 12. "Toradol" is a brand name for Ketorolac and a dangerous drug within the meaning of
14 Business and Professions Code section 4022, in that it requires a prescription under federal law.

15 13. "Fentanyl" is a Schedule II controlled substance as designated by Health and Safety
16 Code section 11055(c)(8).

1 14. "Zofran," a brand of Ondansetron Hydrochloride, is a dangerous drug within the
2 meaning of Code section 4022 in that it requires a prescription under federal law.

3 **FIRST CAUSE FOR DISCIPLINE**

4 **(Out-of-State Discipline)**

5 15. Respondent is subject to discipline under Code section 2761(a)(4), in that effective
6 July 16, 2010, pursuant to a Consent Order ("Order"), in a disciplinary proceeding titled, "*In the*
7 *Matter of: Steven Wade Swihart, License No. 1-107523*," ABN Case No. 2009-0999/2010-0163,
8 Respondent's Alabama Registered Practical Nurse License Number 1-107523, was suspended
9 until such time as Respondent provides to the Alabama Board documentation of completion of
10 numerous requirements, including comprehensive evaluations, successful completion of the initial
11 phase of a treatment program, participation in an aftercare program, negative random monthly
12 drug screens, and active participation in Twelve Step meetings. Upon receipt of satisfactory
13 documentation of such prerequisites, which must be provided within the first 12 months
14 following the effective date of the Order, Respondent's Alabama nursing license will be
15 reinstated on probation for 60 months on terms and conditions. If Respondent fails to provide the
16 documentation within those first 12 months, Respondent's Alabama nursing license will be
17 considered revoked. The Order was based on numerous Findings of Fact, including the
18 following: 1) Respondent diverted narcotics for self use from his employers (Southeast Alabama
19 Medical Center and Highland Hospital); 2) Respondent was convicted of driving under the
20 influence of alcohol in 2001 and 2008; 3) Respondent falsified his Alabama registered nurse
21 license renewal application by failing to disclose his 2008 conviction; and 4) Respondent failed to
22 disclose his entire employment history when completing applications for employment at Troy
23 Regional Medical Center in Alabama, and TravelMax in Florida. The Order is attached hereto as
24 **Exhibit A** and incorporated herein by reference.

25 ///

26 ///

27 ///

28 ///

1 **GLENDALE MEMORIAL HOSPITAL AND HEALTH CENTER**

2 **SECOND CAUSE FOR DISCIPLINE**

3 **(Falsified, Made Incorrect or Inconsistent Entries In Hospital or Patient Records)**

4 16. Respondent is subject to discipline under Code section 2761(a), on the grounds of
5 unprofessional conduct as defined in Code section 2762(e), in that between January 18, 2009, and
6 February 3, 2009, while employed as a registered nurse at Glendale Memorial Hospital and
7 Health Center, located in Glendale, California, Respondent falsified, made grossly incorrect,
8 grossly inconsistent or unintelligible entries in hospital or patient records in the following
9 respects:

10 **Patient 1:**

11 a. On or about January 18, 2009, at 1304 hours, Respondent signed out one (1) 10 mg.
12 ampule of Morphine. Respondent charted the administration of 6 mg. of Morphine at 1310 hours
13 on the patient's Medication Administration Record ("MAR"), but failed to account for the
14 disposition of the remaining 4 mg. of Morphine in any hospital or patient record.

15 **Patient 3:**

16 b. On or about January 18, 2009, at 2254 hours, Respondent signed out one (1) 2 mg.
17 ampule of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 2317 hours
18 on the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid
19 in any hospital or patient record.

20 c. On or about January 18, 2009, at 2354 hours, Respondent signed out one (1) 2 mg.
21 ampule of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 2355 hours
22 on the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid
23 in any hospital or patient record.

24 **Patient 7:**

25 d. On or about January 21, 2009, at 2020 hours, Respondent signed out one (1) 10 mg.
26 ampule of Morphine, but failed to account for the disposition of the Morphine in any hospital or
27 patient record.

28 ///

1 **Patient 8:**

2 e. On or about January 21, 2009, at 1745 hours, Respondent signed out fourteen (14)
3 30 mg. syringes of Toradol. Respondent charted the administration of 30 mg. of Toradol at
4 1740 hours on the patient's MAR, but failed to account for the disposition of the remaining
5 thirteen (13) 30 mg. syringes of Toradol in any hospital or patient record.

6 **Patient 9:**

7 f. On or about January 21, 2009, at 2141 hours, Respondent signed out one (1) 2 mg.
8 vial of Ativan. Respondent charted the administration of 1 mg. of Ativan at 2150 hours on the
9 patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Ativan in any
10 hospital or patient record.

11 g. On or about January 21, 2009, at 2222 hours, Respondent signed out one (1) 10 mg.
12 ampule of Morphine. Respondent charted the administration of 4 mg. of Morphine at 2220 hours
13 on the patient's MAR, but failed to account for the disposition of the remaining 6 mg. of
14 Morphine in any hospital or patient record.

15 **Patient 11:**

16 h. On or about January 23, 2009, at 1652 hours, Respondent signed out one (1) 2 mg.
17 ampule of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 1650 hours
18 on the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid
19 in any hospital or patient record.

20 **Patient 12:**

21 i. On or about January 23, 2009, at 1730 hours, Respondent signed out one (1) 2 mg.
22 ampule of Dilaudid. Respondent charted the administration of 0.5 mg. of Dilaudid at 1747 hours
23 on the patient's MAR, but failed to account for the disposition of the remaining 1.5 mg. of
24 Dilaudid in any hospital or patient record.

25 **Patient 13:**

26 j. On or about January 24, 2009, at 1049 hours, Respondent signed out one (1) 2 mg.
27 vial of Ativan. Respondent charted the administration of 1 mg. of Ativan at 1047 hours on the
28

1 patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Ativan in any
2 hospital or patient record.

3 **Patient 14:**

4 k. On or about January 24, 2009, at 1232 hours, Respondent signed out one (1) 10 mg.
5 ampule of Morphine without a physician's order. Respondent charted the administration of 2 mg.
6 of Morphine at 1250 hours on the patient's MAR, but failed to account for the disposition of the
7 remaining 8 mg. of Morphine in any hospital or patient record. In addition, Respondent was not
8 assigned to care for this patient.

9 **Patient 15:**

10 l. On or about January 24, 2009, at 1239 hours, Respondent signed out one (1) 2 mg.
11 ampule of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 1220 hours
12 on the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid
13 in any hospital or patient record.

14 m. On or about January 24, 2009, at 1419 hours, Respondent signed out one (1) 2 mg.
15 ampule of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 1420 hours
16 on the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid
17 in any hospital or patient record.

18 **Patient 16:**

19 n. On or about January 24, 2009, at 1550 hours, Respondent signed out one (1) 10 mg.
20 ampule of Morphine. Respondent charted the administration of 4 mg. of Morphine at 1800 hours
21 on the patient's MAR, but failed to account for the disposition of the remaining 6 mg. of
22 Morphine in any hospital or patient record.

23 **Patient 17:**

24 o. On or about January 24, 2009, at 1906 hours, Respondent signed out one (1) 10 mg.
25 ampule of Morphine. Respondent charted the administration of 4 mg. of Morphine at 1905 hours
26 on the patient's MAR, but failed to account for the disposition of the remaining 6 mg. of
27 Morphine in any hospital or patient record.

28 ///

1 p. On or about January 24, 2009, at 1934 hours, Respondent signed out one (1) 2 mg.
2 ampule of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 1935 hours
3 on the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid
4 in any hospital or patient record.

5 q. On or about January 24, 2009, at 2107 hours, Respondent signed out one (1) 2 mg.
6 ampule of Dilaudid, but failed to account for the disposition of Dilaudid in any hospital or patient
7 record.

8 **Patient 18:**

9 r. On or about January 25, 2009, at 1241 hours, Respondent signed out one (1) 2 mg.
10 ampule of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 1234 hours
11 on the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid
12 in any hospital or patient record.

13 s. On or about January 25, 2009, at 1700 hours, Respondent charted the administration
14 of 1 mg. of Dilaudid on the patient's MAR, however, Respondent did not sign out Dilaudid at that
15 time.

16 **Patient 19:**

17 t. On or about January 25, 2009, at 1329 hours, Respondent signed out one (1) 10 mg.
18 ampule of Morphine, but failed to account for the disposition of the Morphine in any hospital or
19 patient record.

20 u. On or about January 25, 2009, at 1351 hours, Respondent signed out one (1) 2 mg.
21 syringe of Morphine, but failed to account for the disposition of the Morphine in any hospital or
22 patient record.

23 v. On or about January 25, 2009, at 1351 hours, Respondent signed out one (1) 2 mg.
24 vial of Ativan, but failed to account for the disposition of the Ativan in any hospital or patient
25 record.

26 **Patient 20:**

27 w. On or about January 25, 2009, at 1343 hours, Respondent signed out one (1) 2 mg.
28 ampule of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 1345 hours

1 on the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid
2 in any hospital or patient record.

3 **Patient 21:**

4 x. On or about January 25, 2009, at 1625 hours, Respondent signed out one (1) 10 mg.
5 ampule of Morphine. Respondent charted the administration of 4 mg. of Morphine at 1608 hours
6 on the patient's MAR, but failed to account for the disposition of the remaining 6 mg. of
7 Morphine in any hospital or patient record.

8 **Patient 22:**

9 y. On or about January 25, 2009, at 1234 hours, Respondent charted the administration
10 of 1 mg. of Dilaudid. However, there is no corresponding withdraw of Dilaudid at that time.

11 z. On or about January 25, 2009, at 1659 hours, Respondent signed out one (1) 2 mg.
12 ampule of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 1700 hours
13 on the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid
14 in any hospital or patient record.

15 **Patient 23:**

16 aa. On or about February 2, 2009, at 1949 hours, Respondent signed out one (1) 10 mg.
17 ampule of Morphine. Respondent charted the administration of 4 mg. of Morphine at 1946 hours
18 on the patient's MAR, but failed to account for the disposition of the remaining 6 mg. of
19 Morphine in any hospital or patient record.

20 bb. On or about February 2, 2009, at 1952 hours, Respondent documented that he
21 returned one (1) 10 mg. ampule of Morphine. However, there is no corresponding withdrawal of
22 Morphine at that time.

23 **Patient 27:**

24 cc. On or about February 3, 2009, at 0044 hours, Respondent signed out one (1) 2 mg.
25 vial of Ativan. Respondent charted the administration of 1 mg. of Ativan at 0057 hours on the
26 patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Ativan in any
27 hospital or patient record.

28 ///

1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Obtained, Possessed, and Self-Administered Controlled Substances)**

3 17. Respondent is subject to discipline under Code section 2761(a), on the grounds of
4 unprofessional conduct as defined in Code section 2762(a), in that between January 18, 2009, and
5 February 3, 2009, while employed as a registered nurse at Glendale Memorial Hospital and
6 Health Center, located in Glendale, California, Respondent did the following:

7 a. Respondent obtained Morphine, Dilaudid, and Ativan, all controlled substances, by
8 fraud, deceit, misrepresentation or subterfuge or by the concealment of a material fact in violation
9 of Health and Safety Code section 11173(a) when, while on duty, Respondent signed out
10 medications for the administration to various patients, then administer the proper dosage to the
11 patient, and take any remaining or excess amount for his own personal use.

12 b. Respondent possessed Morphine, Dilaudid, and Ativan, all controlled substances, in
13 violation of Code section 4060, in that he did not have a prescription for those controlled
14 substances.

15 c. Respondent self-administered Morphine, Dilaudid, and Ativan, all controlled
16 substances, without direction to do so from a licensed physician and surgeon, dentist or podiatrist.

17 **FOURTH CAUSE FOR DISCIPLINE**

18 **(Use of Controlled Substances)**

19 18. Respondent is subject to discipline under Code section 2761(a), on the grounds of
20 unprofessional conduct as defined in Code section 2762(b), in that between January 18, 2009, and
21 February 3, 2009, while on duty as a registered nurse at Glendale Memorial Hospital and Health
22 Center, located in Glendale, California, Respondent used controlled substances to an extent or in
23 a manner dangerous or injurious to himself, any other person, or the public or to the extent that
24 such use impaired his ability to conduct with safety to the public the practice authorized by his
25 license.

26 ///

27 ///

28 ///

1 ALAMEDA COUNTY MEDICAL CENTER - HIGHLAND HOSPITAL

2 FIFTH CAUSE FOR DISCIPLINE

3 (Falsified, Made Incorrect or Inconsistent Entries In Hospital or Patient Records)

4 19. Respondent is subject to discipline under Code section 2761(a), on the grounds of
5 unprofessional conduct as defined in Code section 2762(e), in that between October 8, 2009, and
6 October 13, 2009, while employed as a registered nurse by TravelMax (registry), and on
7 assignment at Alameda County Medical Center - Highland Hospital, located in Oakland,
8 California, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible
9 entries in hospital or patient records in the following respects:

10 Patient A:

11 a. On or about October 8, 2009, at 1738 hours, Respondent signed out one (1) 2 mg. vial
12 of Ativan, but failed to account for the disposition of the Ativan in any hospital or patient record.
13 In addition, Respondent was not assigned to care for this patient.

14 Patient C:

15 b. On or about October 10, 2009, at 1734 hours, Respondent signed out one (1) 4 mg.
16 vial of Morphine, but failed to account for the disposition of the Morphine in any hospital or
17 patient record.

18 Patient D:

19 c. On or about October 9, 2009, at 1207 hours, Respondent signed out one (1) 8 mg. vial
20 of Morphine, but failed to account for the disposition of the Morphine in any hospital or patient
21 record. In addition, Respondent was not assigned to care for this patient.

22 Patient E:

X 23 d. On or about October 11, 2009, at 1337 hours, Respondent signed out one
24 (1) 100 mcg. vial of Fentanyl, but failed to account for the disposition of the Fentanyl in any
25 hospital or patient record. In addition, Respondent was not assigned to care for this patient.

26 ///

27 ///

28 ///

1 **Patient J:**

2 e. On or about October 13, 2009, at 0753 hours, Respondent signed out one
3 (1) 100 mcg. vial of Fentanyl, but failed to account for the disposition of the Fentanyl in any
4 hospital or patient record. In addition, Respondent was not assigned to care for this patient.

5 **Patient P:**

6 f. On or about October 11, 2009, at 1551 hours, Respondent signed out one (1) 2 mg.
7 vial of Morphine without a physician's order, and failed to account for the disposition of the
8 Morphine in any hospital or patient record. In addition, the patient was discharged at 1210 hours
9 (more than 3 hours prior).

10 **Patient Q:**

11 g. On or about October 13, 2009, at 0721 hours, Respondent signed out one (1) 2 mg.
12 vial of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 0711 hours on
13 the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid in
14 any hospital or patient record.

15 h. On or about October 13, 2009, at 0859 hours, Respondent signed out one (1) 2 mg.
16 vial of Dilaudid, but failed to account for the disposition of the Dilaudid in any hospital or patient
17 record.

18 **Patient R:**

19 i. On or about October 11, 2009, at 1144 hours, Respondent signed out one (1) 2 mg.
20 vial of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 1139 hours on
21 the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid in
22 any hospital or patient record.

23 j. On or about October 11, 2009, at 1751 hours, Respondent signed out one (1) 2 mg.
24 vial of Morphine without a physician's order, and failed to account for the disposition of the
25 Morphine in any hospital or patient record.

26 ///

27 ///

28 ///

1 **Patient S:**

2 k. On or about October 13, 2009, at 1230 hours, Respondent charted the administration
3 of 1 mg. of Dilaudid on the patient's MAR. However, there was not a corresponding withdrawal
4 of Dilaudid at that time, nor was there a physician's order for the administration of Dilaudid.

5 l. On or about October 13, 2009, at 1345 hours, Respondent signed out one (1) 2 mg.
6 vial of Dilaudid. At 1456 hours, Respondent cancelled the removal of Dilaudid. (Respondent
7 was terminated at 1445 hours, 11 minutes prior to canceling the removal of Dilaudid.)

8 **Patient V:**

9 m. On or about October 10, 2009, at 1346 hours, Respondent signed out one (1) 4 mg.
10 vial of Zofran without a physician's order, and failed to account for the disposition of the Zofran
11 in any hospital or patient record.

12 n. On or about October 10, 2009, at 1309 hours, Respondent signed out one (1) 2 mg.
13 vial of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 1313 hours on
14 the patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid in
15 any hospital or patient record.

16 o. On or about October 10, 2009, at 1346 hours, Respondent signed out one (1) 2 mg.
17 vial of Dilaudid without a physician's order. Respondent documented wasting 1 mg. of Dilaudid
18 at 1531 hours, but failed to account for the disposition of the remaining 1 mg. of Dilaudid in any
19 hospital or patient record.

20 **Patient Z:**

21 p. On or about October 8, 2009, at 1212 hours, Respondent signed out one (1) mg. vial
22 of Ativan, but failed to account for the disposition of the Ativan in any hospital or patient record.
23 In addition, Respondent was not assigned to care for this patient.

24 **Patient AA:**

25 q. On or about October 8, 2009, at 1235 hours, Respondent signed out one (1) 2 mg. vial
26 of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 1237 hours on the
27 patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid in any
28 hospital or patient record.

1 r. On or about October 8, 2009, at 1251 hours, Respondent signed out one (1) 2 mg. vial
2 of Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid at 1250 hours on the
3 patient's MAR, but failed to account for the disposition of the remaining 1 mg. of Dilaudid in any
4 hospital or patient record.

5 **Patient BB:**

6 s. On or about October 9, 2009, at 1550 hours, Respondent signed out one (1) 10 mg.
7 vial of Morphine, but failed to account for the disposition of the Morphine in any hospital or
8 patient record. In addition, Respondent was not assigned to care for this patient.

9 t. On or about October 9, 2009, at 1908 hours, Respondent signed out one (1) 2 mg. vial
10 of Morphine without a physician's order. At 1909 hours, Respondent signed out one (1) 4 mg.
11 vial of Morphine without a physician's order. Respondent charted the administration of 6 mg. of
12 Morphine at 1905 hours on the patient's MAR, when the physician's orders did not call for the
13 administration of that medication.

14 **SIXTH CAUSE FOR DISCIPLINE**

15 **(Obtained, Possessed, and Self-Administered Controlled Substances)**

16 20. Respondent is subject to discipline under Code section 2761(a), on the grounds of
17 unprofessional conduct as defined in Code section 2762(a), in that between October 8, 2009, and
18 October 13, 2009, while employed as a registered nurse by TravelMax (registry), and on
19 assignment at Alameda County Medical Center - Highland Hospital, located in Oakland,
20 California, Respondent did the following:

21 a. Respondent obtained Morphine, Dilaudid, Ativan, and Fentanyl, all controlled
22 substances, by fraud, deceit, misrepresentation or subterfuge or by the concealment of a material
23 fact in violation of Health and Safety Code section 11173(a) when, while on duty, Respondent
24 signed out the medications for administration to various patients, but took them for his own
25 personal use.

26 b. Respondent possessed Morphine, Dilaudid, Ativan, and Fentanyl, all controlled
27 substances, in violation of Code section 4060, in that he did not have a prescription for those
28 controlled substances.

c. Respondent self-administered Morphine, Dilaudid, Ativan, and Fentanyl, all controlled substances, without direction to do so from a licensed physician and surgeon, dentist or podiatrist.

SEVENTH CAUSE FOR DISCIPLINE

(Use of Controlled Substances)

21. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(b), in that between October 8, 2009, and October 13, 2009, while employed as a registered nurse by TravelMax (registry), and on assignment at Alameda County Medical Center - Highland Hospital, located in Oakland, Respondent used controlled substances to an extent or in a manner dangerous or injurious to himself, any other person, or the public or to the extent that such use impaired his ability to conduct with safety to the public the practice authorized by his license.

EIGHTH CAUSE FOR DISCIPLINE

(Obtained, Possessed, and Self-Administered Controlled Substances)

22. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(a), in that in and between 2006 and 2010, Respondent obtained and possessed, in violation of law, and self-administered unknown amounts of controlled substances while on duty as a registered nurse at the following facilities:

<u>Facility</u>	<u>Time Employed</u>
Flowers Hospital, Dothan, AL	2006-2007 (14 months)
Southeast Alabama Medical Center, Dothan, AL	2007-2008 (2 years)
Kaiser Permanente, Sacramento, CA	2008 (3 months)
Care South Home Health, AL	2008
Pomona Valley Hospital Medical Center, Pomona, CA	2009 (3 months)
Troy Regional Medical Center, Troy, AL	2009 (2 months)
Sutter Memorial Hospital, Sacramento, CA	2009 (3 months)
White Memorial Hospital, Los Angeles, CA	2010 (3 months)

NINTH CAUSE FOR DISCIPLINE

(Conviction of a Crime)

23. Respondent is subject to discipline under Code section 2761(f), in that on or about November 7, 2008, in the case of *People v. Steven Wade Swihart*, (Super. Ct. Sacramento County,

1 Case No. 08T04485), Respondent was convicted by the Court on his plea of nolo contendere of
2 violating Vehicle Code section 23152(b) (driving with a blood alcohol level of .08% or higher), a
3 crime that is substantially related to the qualifications, functions or duties of a licensed registered
4 nurse. The circumstances of the crime were that on or about July 1, 2008, Respondent drove a
5 vehicle while having a blood alcohol level of 0.16%.

6 **TENTH CAUSE FOR DISCIPLINE**

7 **(Dangerous Use of Alcohol)**

8 24. Respondent is subject to discipline under Code sections 2761(a), on the grounds of
9 unprofessional conduct, as defined in Code section 2762(b), in that on or about July 1, 2008,
10 Respondent used an alcoholic beverage to an extent or in a manner dangerous or injurious to
11 himself and the public when he operated a motor vehicle with a blood alcohol level of 0.16%.

12 **ELEVENTH CAUSE FOR DISCIPLINE**

13 **(Conviction Involving the Consumption of Controlled Substances and Alcohol)**

14 25. Respondent is subject to discipline under Code section 2761(a), on the grounds of
15 unprofessional conduct as defined in Code section 2762(c), in that on or about November 7, 2008,
16 Respondent was convicted of a crime involving the consumption of alcohol, as more particularly
17 set forth above in paragraph 23.

18 **TWELFTH CAUSE FOR DISCIPLINE**

19 **(Securing a License by Fraud, Deceit, or Misrepresentation)**

20 26. Respondent is subject to discipline under Code sections 2761, subdivision (e), and
21 498, in that Respondent gave false information and misrepresented a material fact in connection
22 with an application for licensure, in the following respects:

23 a. On or about September 8, 2008, on Respondent's Alabama application for renewal of
24 licensure, Respondent failed to disclose his arrest on July 1, 2008, as more particularly set forth
25 above in paragraph 23.

26 b. On or about October 15, 2009, on Respondent's California application for renewal of
27 licensure, Respondent failed to disclose his conviction of November 7, 2008, as more particularly
28 set forth above in paragraph 23.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 727110, issued to Steven Wade Swihart;
2. Ordering Steven Wade Swihart to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,
3. Taking such other and further action as deemed necessary and proper.

DATED: July 7, 2011

Louise R. Bailey
LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2010102517
10681497.doc

Exhibit A
Consent Order

BEFORE THE ALABAMA BOARD OF NURSING

IN THE MATTER OF:

STEVEN WADE SWIHART

LICENSE NO. 1-107523

Respondent.

ABN CASE NO. 2009-0999; 2010-0163

CONSENT ORDER

The Alabama Board of Nursing, hereinafter referred to as Board, having evidence that **STEVEN WADE SWIHART**, hereinafter referred to as Respondent, is in violation of the Code of Alabama 1975, § 34-21-25, and the Alabama Board of Nursing Administrative Code, § 610-X-8; and Respondent, desiring to avoid the necessity of a formal hearing, do hereby enter into this Consent Order in lieu of proceeding with further disciplinary action. Respondent understands the right to a formal hearing in this matter and hereby knowingly waives such right. Respondent further understands and agrees that this is a non-appealable Order.

FINDINGS OF FACT

I.

On January 11, 2006, Respondent was licensed by the Alabama Board of Nursing as a Registered Nurse and was so licensed at all times relevant to the matters stated herein. Respondent is currently licensed through December 31, 2010.

II.

On May 28, 2008, Respondent was issued Registered Nurse license number 727110 by the California Board of Registered Nursing. The license status is active with an expiration date of November 30, 2011.

III.

On June 5, 2009, Respondent self reported to the Director of the Voluntary Disciplinary Alternative Program that he has been stealing injectable morphine and Dilaudid for self use orally from his Alabama employer and while he was on assignment in California. Additionally, Respondent admitted that he was charged with DUI while in California in 2008 and that he had not disclosed this on his recent renewal application.

IV.

On September 10, 2000, Respondent was arrested and charged with Failure to Maintain Lane, Driving Under Influence Alcohol, No Proof of Insurance, and Open Container in Marietta, Georgia. On January 11, 2001, Respondent pleaded guilty to Driving Under Influence Alcohol, No Proof of Insurance, and Open Container in the Municipal Court of Marietta, Georgia.

V.

According to a criminal report contained in documents provided by Alameda County Medical Center, Oakland, California, a charge of Driving Under the Influence (0.08%) was filed against Respondent on July 31, 2008, in Superior Court, Sacramento, California (case number 08T04485). On November 7, 2008, Respondent pleaded no contest to Driving Under the Influence (0.08%), a misdemeanor, and was sentenced to three years informal probation and 48 hours Sheriff's Work Project.

VI.

On September 8, 2008, Respondent submitted to the Alabama Board of Nursing an application for renewal of his Registered Nurse license. On this application, Respondent answered "no" to the question "[s]ince your last renewal, were you arrested for and/or charged with any crime other than a minor traffic violation? Any arrest and/or charge related to driving while impaired or while under the influence of any substance is not a 'minor traffic violation.'"

As described in Paragraph V above, a charge of Driving Under the Influence (0.08%) was filed against Respondent on July 31, 2008, in Superior Court, Sacramento, California (case number 08T04485).

VII.

Between April 20, 2009, and June 5, 2009, Respondent was employed by Southeast Alabama Medical Center, Dothan, Alabama, as a Registered Nurse. Respondent was a rehire at the time of his April 20, 2009, employment. On June 5, 2009, Respondent's employment was terminated following his admission that he diverted drugs from the hospital for his personal use.

VIII.

On or about June 4, 2009, while employed as a Registered Nurse by Southeast Alabama Medical Center, Dothan, Alabama, Respondent received a written warning and was placed back into orientation for two weeks on 6 East due to the following:

- one parking violation (April 30, 2009) since his rehire and eight parking violations that occurred during his employment the previous year
- unprofessional conduct when on April 29, 2009, he used the bathroom of an occupied patient room on 5 East to void
- medication error on 4 East
- two medication errors on 2 East
- mishandled medication on BMU when a patient reported not receiving Glucophage and the Glucophage pill was left on the medication cart
- report from BMU charge nurse that Respondent does not listen to suggestions and "does things his own way"
- did not follow through with a permit that was to be signed by a 6 East patient for surgery, did not prepare the patient for surgery, and did not report these needs to the on-coming nurse on May 29, 2009

- unit of packed red blood cells left hanging for six hours on 5 East patient
- Vancomycin IVPB was not given at 0600 on June 1, 2009

IX.

On June 5, 2009, while employed as a Registered Nurse by Southeast Alabama Medical Center, Dothan, Alabama, and assigned to 6 East for re-training, Respondent tested negative on a reasonable suspicion drug screen. Prior to submitting to the drug screen, Respondent stated to his employer "I am abusing pain medications"; explained that he drinks them but had not done so that day; and he had used Dilaudid the morning of June 4, 2009.

The basis for the drug screen was a June 4, 2009, report from a registered nurse on 6 East that Respondent removed two vials of Ativan from his pocket and asked her to "witness" the waste; the receipt of a report from the Clinical Coordinator on 7 East of her concern that a patient whom Respondent provided care to appeared heavily sedated and was hypotensive when another nurse assumed care of the patient; and a review of Omnicel transactions by Respondent which identified narcotics that were removed but not documented as given, wastes witnessed two to four hours after medication was given, and narcotics that were given too early.

X.

On June 10, 2009, Respondent completed an application for Registered Nurse employment at Troy Regional Medical Center, Troy, Alabama. Respondent listed his previous employment at Southeast Alabama Medical Center from August 2006 to May 2008, but did not list his most recent employment with this employer.

As described in Paragraph VII above, Respondent was employed by Southeast Alabama Medical Center, Dothan, Alabama, from April 20, 2009, to June 5, 2009, when his employment was terminated following his admission that he diverted drugs from the hospital for his personal use.

XI.

On July 28, 2009, Respondent completed a travel candidate application for TravelMax, Tampa, Florida. Respondent listed his previous employment at Southeast Alabama Medical Center from August 20, 2006, to May 30, 2008, but did not list his most recent employment with this employer.

As described in Paragraph VII above, Respondent was employed by Southeast Alabama Medical Center, Dothan, Alabama, from April 20, 2009, to June 5, 2009, when his employment was terminated following his admission that he diverted drugs from the hospital for his personal use.

XII.

On October 23, 2009, the Alabama Board of Nursing received an employer report from TravelMax, Tampa, Florida, which reported the termination of Respondent's 13 week travel contract by Highland Hospital, Oakland, California, after Respondent used profanity in his response to a patient; and following the termination of his contract, concerns with Respondent's activity in a PYXIS station at the hospital were identified.

XIII.

According to documentation from Alameda County Medical Center-Highland Campus, Oakland, California, Respondent came to the Medical Center on October 5, 2009, as a traveling RN and worked a total of four 12-hour shifts before his contract was cancelled. On his first day of duty, Respondent made a derogatory racial comment about a patient to another staff member and later that same day he used profanity toward a patient. On his second day, he did not use sterile procedure when he inserted a foley catheter and replied "that's what antibiotics are for" when questioned about this by another nurse. On October 13, 2009, Respondent was removed from patient care, counseled and sent home at approximately 1445. Respondent's badge was collected and he was clocked out of the system. At 1606, a discrepancy was discovered in the expected amount of Dilaudid 2 mg/ 1 ml vial in Station ER2 (expected six,

found three). Respondent was identified as the user with prior access at 1456 when Dilaudid 2 mg/ 1 ml vial in Station ER2 was accessed as "cancelled removal" and six vials were identified in the beginning and ending count.

XIV.

PYXIS station printouts for station ER2 at Alameda County Medical Center-Highland Campus, Oakland, California, reflect the following activity by Respondent on October 13, 2009:

TIME	ACTIVITY	DRUG	PATIENT INITIALS	COMMENTS
07:46	WASTED	1 mg Hydromorphone 2 mg/ 1 ml vial	SM	Removed by Respondent at 07:21, removed dose held for twenty five prior to waste that occurs without a witness
10:02	RETURNED	(1) Fentanyl (100 mcg/2 ml) 2 ml syringe	JG	Removed by Respondent at 10:01, returned one minute later (see activity at 10:34)
10:33	WASTED	2 mg Hydromorphone 2 mg/ 1 ml vial	JS	Removed by Respondent at 08:36; removed dose held for one hour and fifty seven minutes prior to waste.
10:34	WASTED	50 mcg Fentanyl (100 mcg/2 ml) 2 ml syringe	JG	Removed by Respondent at 09:59, removed dose held for 35 minutes prior to waste
11:15	WASTED	1 mg Hydromorphone 2 mg/ 1 ml vial	JG	Removed by Respondent at 11:10, removed dose held for 5 minutes prior to waste
11:54	WASTED	3 mg Hydromorphone 2 mg/ 1 ml vial	AO	(2) Removed by Respondent at 11:49, removed dose held for 5 minutes prior to waste
12:43	WASTED	50 mcg Fentanyl (100 mcg/2 ml) 2 ml syringe	AR	Removed by Respondent at 12:39, removed dose held for 4 minutes prior to waste
14:46	CANCELLED REMOVAL	Hydromorphone 2 mg/ 1 ml vial		Beginning 6 Ending 6 At 16:06 a discrepancy occurs, expected 6 but found 3 - three Hydromorphone 2 mg/ 1ml vials unaccounted for and Respondent is identified as the user with prior access

XV.

An Alameda County Medical Center-Highland Campus, Oakland, California, All Station Events Report for September 15, 2009, to October 14, 2009, reflects the following activity by Respondent:

DATE	TIME	STATION	DRUG	COMMENTS
10/8/09	12:35	ER3	(1) Hydromorphone 2 mg / 1 ml vial	Page 7
10/8/09	12:51	ER3	(1) Hydromorphone 2 mg / 1 ml vial	Page 7 Written comment – "q1° prn orders" See above, sixteen minutes since prior removal
10/8/09	14:20	ER3	1 mg waste Hydromorphone 2 mg / 1 ml vial	Page 8 Removed at 12:35, removed dose held 1 hour forty five minutes prior to waste and removed another dose at 12:51 when waste of 12:35 dose had not occurred
10/8/09	14:21	ER3	1 mg waste Hydromorphone 2 mg / 1 ml vial	Page 8 Removed at 12:51, removed dose held 1 hour thirty minutes prior to waste See above
10/8/09	14:28	ER3	(1) Hydromorphone 2 mg / 1 ml vial	Page 8
10/8/09	15:01	ER3	(1) Hydromorphone 2 mg / 1 ml vial	Page 8 Written comment Page 7 – "q1° prn orders" See above, thirty-three minutes since prior removal
10/9/09	15:50	ER3	(1) Morphine Sulfate 10 mg/ 1 ml syringe	Page 2 Written comment – "orders for MSO4 6 mg x 2 [and] Fentanyl 200 mcg" No waste with this transaction
10/9/09	19:08	ER1	(1) Morphine Sulfate 2 mg / 1ml syringe	Page 2 See above comment

10/9/09	19:09	ER1	(1) Morphine Sulfate 4 mg / 1 ml syringe	Page 2 See above comment
10/10/09	13:46	ER1	(1) Hydromorphone 2 mg / 1 ml vial	Page 7
10/10/09	15:31	ER1	1 mg waste Hydromorphone 2 mg / 1 ml vial	Page 7 Removed at 13:46, removed dose held 1 hour and forty five minutes prior to waste
10/10/09	17:34	ER1	(1) Morphine Sulfate 4 mg / 1 ml syringe	Page 1 Written comment – "Pt. has order for Morphine 4 mg x 1, 8 mg removed"
10/10/09	19:13	ER2	(1) Morphine Sulfate 4 mg / 1 ml syringe	Page 1 See above comment A discrepancy occurs with this transaction, expected 23, found 18 Respondent identified the beginning count as 18, the discrepancy is resolved with a witness at 19:15 and the reason for the discrepancy is "miscount x 2".
10/11/09	13:37	ER2	(1) Fentanyl (100 mcg / 2 ml) 2 ml syringe	Page 2 Written comment – "Also had order Dilaudid 2 mg"
10/11/09	15:51	ER1	(1) Morphine Sulfate 2 mg / 1 ml syringe	Page 5 Written comment – "pt d/c'd @ 1210 [and] Ø orders"
10/11/09	17:51	ER1	(1) Morphine Sulfate 2 mg / 1 ml syringe	Page 5 Written comment – "Ø order"
10/13/09	08:36	ER2	(1) Hydromorphone 2 mg / 1 ml vial	Page 7 Written comment – "orders for Dilaudid 1mg x 1 then 1 mg prn q1"
10/13/09	10:33	ER2	2 mg waste Hydromorphone 2 mg / 1 ml vial	Page 7 Removed at 08:36, removed dose held

				1 hour and fifty seven minutes prior to waste of entire dose
10/13/09	09:59	ER2	(1) Fentanyl (100 mcg/ 2 ml) 2 ml syringe	Page 3 Written comment – "order for Fent. 50 mcg [and] Dilaudid 1. mg" No waste with this transaction, see activity at 10:34
10/13/09	10:01	ER3	(1) Fentanyl (100 mcg/ 2 ml) 2 ml syringe	Page 3 See above comment
10/13/09	10:02	ER3	(1) – returned to bin Fentanyl (100 mcg/ 2 ml) 2 ml syringe	Page 3 See above comment
10/13/09	10:34	ER2	50 mcg waste Fentanyl (100 mcg/ 2 ml) 2 ml syringe	Page 3 Removed at 09:59, removed dose held 35 minutes prior to waste
10/13/09	11:10	ER3	(1) Hydromorphone 2 mg / 1 ml vial	Page 3 See above comments
10/13/09	11:15	ER3	1 mg waste Hydromorphone 2 mg / 1 ml vial	Page 4 Removed at 11:10, removed dose held 5 minute prior to waste
10/13/09	11:49	ER3	(2) Hydromorphone 2 mg / 1 ml vial	Page 6
10/13/09	11:54	ER3	3 mg waste Hydromorphone 2 mg / 1 ml vial	Page 6 Removed two 2 mg vials for total dose of 4 mg at 11:49, removed dose held 5 minutes prior to waste

XVI.

On May 5, 2010, Respondent was evaluated by Dr. P. Lane, UAB Addiction Recovery Program, Birmingham, Alabama, a Board recognized treatment provider. Respondent received the following recommendations: full substance abuse treatment, short term (< 45 days) clinically managed residential services with healthcare professional program and evaluation by a psychiatrist.

CONCLUSIONS OF LAW

1. Respondent's admission that he has been stealing injectable morphine and Dilaudid for self use orally from his Alabama employer and while he was on assignment in California and his convictions for Driving Under the Influence, all as further described in Paragraphs III through V, VII through IX, and XII through XVI of the Findings of Fact, demonstrate that Respondent is addicted to the use of habit-forming drugs to such an extent as to render him unsafe or unreliable as a licensee in violation of Code of Alabama 1975, § 34-21-25(b)(1)(d) and the Alabama Board of Nursing Administrative Code § 610-X-8-.04(b), (d) and (h).
2. Respondent's conduct as described in Paragraphs IV and V of the Findings of Fact demonstrates that Respondent has been convicted of any conduct detrimental to the public's health, safety or welfare in violation of Code of Alabama 1975, § 34-21-25(b)(1)(c) and the Alabama Board of Nursing Administrative Code § 610-X-8-.03(3)(h).
3. Respondent's conduct as described in Paragraph VI of the Findings of Fact demonstrates that Respondent misrepresented or falsified facts in applying for renewal of license in violation of Code of Alabama 1975, § 34-21-25(b)(1)(a) and the Alabama Board of Nursing Administrative Code § 610-X-8-.03(1)(b).
4. Standards of practice require the registered nurse to be responsible and accountable for the quality of nursing care delivered to patients based on and limited to scope of education, demonstrated competence, and nursing experience; accept individual responsibility and accountability for judgments, actions and nursing competency; and to respect the dignity and rights of patients to be free from exploitation of physical and mental boundaries. Code of Alabama 1975, § 34-21-1(3)(a) and the Alabama Board of Nursing Administrative Code § 610-X-6-.02(3), (6) and (9)(c) (as effective through December 27, 2009). Respondent's conduct as described in Paragraphs III and VII through XV of the Findings of Fact demonstrates that Respondent failed to practice nursing in accordance with the standards of practice adopted by the Board in violation of Code of Alabama 1975, § 34-21-25(b)(1)(g) and the Alabama Board of

Nursing Administrative Code § 610-X-8-.03(6)(b). Said conduct is unprofessional conduct of a character likely to deceive, defraud or injure the public in matters pertaining to health.

5. Respondent's conduct as described in Paragraphs III, VII through IX, and XII through XV of the Findings of Fact demonstrates that Respondent failed to use appropriate nursing judgment, administer medications and treatments in a responsible manner, and demonstrate competence in administering or carrying out patient care in violation of Code of Alabama 1975, § 34-21-25(b)(1)(g) and the Alabama Board of Nursing Administrative Code § 610-X-8-.03(6)(f). Said conduct is unprofessional conduct of a character likely to deceive, defraud or injure the public in matters pertaining to health.

6. Respondent's conduct as described in Paragraphs VIII and IX of the Findings of Fact demonstrates that Respondent failed to make entries in patient or employer records in violation of Code of Alabama 1975, § 34-21-25(b)(1)(g) and the Alabama Board of Nursing Administrative Code § 610-X-8-.03(6)(g). Said conduct is unprofessional conduct of a character likely to deceive, defraud or injure the public in matters pertaining to health.

7. Respondent's conduct as described in Paragraphs III, VII through IX, and XII through XV of the Findings of Fact demonstrates that Respondent exhibited inappropriate or unprofessional conduct or behavior in the workplace in violation of Code of Alabama 1975, § 34-21-25(b)(1)(g) and the Alabama Board of Nursing Administrative Code § 610-X-8-.03(6)(q). Said conduct is unprofessional conduct of a character likely to deceive, defraud or injure the public in matters pertaining to health.

8. Respondent's conduct as described in Paragraphs X and XI of the Findings of Fact demonstrates that Respondent engaged in fraud, deceit or misrepresentation in seeking employment or seeking to practice in violation of Code of Alabama 1975, § 34-21-25(b)(1)(g) and the Alabama Board of Nursing Administrative Code § 610-X-8-.03(6)(r)(iii). Said conduct is unprofessional conduct of a character likely to deceive, defraud or injure the public in matters pertaining to health.

9. Respondent's conduct as described in Paragraphs III, VII, IX, XIII, XIV, and XV of the Findings of Fact demonstrates that Respondent obtained controlled substances except as directed by a legally authorized prescriber in violation of Code of Alabama 1975, § 34-21-25(b)(1)(g) and the Alabama Board of Nursing Administrative Code § 610-X-8-.03(6)(v). Said conduct is unprofessional conduct of a character likely to deceive, defraud or injure the public in matters pertaining to health.

10. Respondent's conduct as described in Paragraphs III, VII, IX, XIII, XIV, and XV of the Findings of Fact demonstrates that Respondent appropriated anything of value, use or benefit in violation of Code of Alabama 1975, § 34-21-25(b)(1)(g) and the Alabama Board of Nursing Administrative Code § 610-X-8-.03(6)(w)(i). Said conduct is unprofessional conduct of a character likely to deceive, defraud or injure the public in matters pertaining to health.

11. The conduct stated above constitutes sufficient grounds for the imposition of sanctions against Respondent's license to practice as a Registered Nurse in the State of Alabama pursuant to the Code of Alabama 1975, § 34-21-25, and the Alabama Board of Nursing Administrative Code, § 610-X-8-.03.

ORDER

Respondent's Alabama Registered/Licensed Practical Nurse License, No. **1-107523**, is hereby **SUSPENDED** until such time as the Board is in receipt of documentation of: (a) required comprehensive evaluations performed pursuant to Stipulation Number 4 below; (b) successful completion of the initial phase of a treatment program as specified in Stipulation Number 5 below; (c) participation in an aftercare program as specified in Stipulation Number 6 below; (d) negative random monthly urine drug screens as specified in Stipulation Number 14 below; (e) active participation in Twelve Step Meetings as specified in Stipulation Number 8 below; (f) accrual of requisite continuing education contact hours; and, (g) payment of appropriate fees. Upon receipt of the above, Respondent's license will be reinstated on **PROBATION** for a period of **SIXTY (60)**

MONTHS pursuant to the terms and conditions in this Order. In no event will this period of suspension extend longer than TWELVE (12) MONTHS past the effective date of this Order. Should such occur, Respondent's licensure status will be considered as and listed as revoked.

1. Return of Wallet ID Card

Respondent's wallet ID card shall be **immediately** returned to the Alabama Board of Nursing office. Upon reinstatement, Respondent will be issued a wallet ID card which indicates probationary status.

2. Duration of Order

The duration of this Order is for a period of sixty (60) months unless extended pursuant to Stipulation Number 4 below. Respondent may apply for early release after thirty-six (36) months of satisfactory compliance with all the stipulations of this Order. If Respondent applies for early release, a comprehensive chemical dependency, physical and mental evaluation from a treatment provider with a healthcare professionals tract which supports early release shall be submitted to the Board. Said evaluation must be performed within the ninety (90) day period immediately prior to submission of the application for early release. This time period is subject to Stipulation Number 24 below:

3. Fine

Respondent shall pay a fine in the amount of **\$1000** for the violations described in Paragraphs 1, 9, and 10 of the Conclusions of Law and a fine in the amount of **\$300** for the violations described in Paragraphs 3 and 8 of the Conclusions of Law, for a total fine of **\$1300**. This fine must be paid within thirty (30) days of the effective date of Respondent's reinstatement. Respondent understands that failure to pay the fine is cause for additional disciplinary action by the Board of Nursing.

4. Evaluations (Chemical Dependency)

Respondent must submit the results of required comprehensive evaluations for chemical dependency, physical and mental illness from a Board-recognized treatment provider

with Board consultation with the evaluating professional prior to making the assessment. Respondent must abide by any requests and recommendations from the providers that may include inpatient evaluation, outpatient evaluation, partial hospitalization evaluation and psychological testing.

Respondent is also required to undergo subsequent evaluations by a recognized provider with a healthcare professionals tract should such be requested by the Board following a relapse or for other cause. Respondent must follow all treatment recommendations from the provider including inpatient treatment, outpatient treatment, halfway house, residential long-term treatment, counseling, etc.

If not eligible for early release, the Respondent shall return to the original treatment provider(s) or other Board-approved provider for required comprehensive evaluations and a determination of readiness to practice without supervision and/or monitoring. Said evaluations must be performed within the ninety (90) day period immediately prior to the scheduled termination of this Order. Based upon the evaluations, the Board may extend the period of this Order and require additional treatment, counseling, etc.

5. Treatment Program

The program must be a Board-recognized chemical dependency treatment program. Respondent shall cause the director of the treatment program to submit to the Board proof of Respondent's entry into a primary intensive alcohol/drug treatment program in accordance with the recommendations made during the evaluation process which may include inpatient treatment, outpatient treatment, halfway house, residential long-term treatment and/or a combination thereof. Respondent shall also cause the program director to provide the Board with documentation concerning Respondent's successful completion of the program, readiness to return to the safe practice of nursing and recommendations and arrangements for appropriate follow-up.

6. Aftercare Program

Unless otherwise recommended by the treatment provider and approved by the Board, the Respondent, within one (1) week of the completion of the initial phase of the treatment program, shall enter a Board-acceptable chemical dependency aftercare program with said program to meet on a weekly basis and to extend for a minimum of one (1) year. Respondent shall also cause the program to submit to the Board, in writing, and on the Board-approved form, documentation of the Respondent's attendance, participation and progress in the program. Such reports are due quarterly, according to schedule, for the duration of the probationary period or until successful completion of the aftercare program. In the event the Respondent is discharged from the aftercare program for noncompliance, the Respondent and the program are to immediately notify the Board, in writing, of such occurrence. This is required regardless of whether Respondent is employed in nursing.

7. Individual/Group Counseling

Respondent shall participate regularly in a Board-acceptable counseling program contingent upon the recommendations of the original treatment program. Respondent shall continue in counseling for as long as deemed necessary by the counselor/therapist. This stipulation is in addition to meeting the stipulation requiring aftercare participation. Respondent shall have the counselor/therapist to notify the Board when continued counseling is no longer indicated and Respondent is discharged or when there is a failure to complete or comply with the course of therapy. Respondent shall also cause the program to submit to the Board, in writing and on the Board-approved form, evidence of satisfactory participation and progress in counseling. Such reports are due quarterly, according to schedule, as long as indicated during the period of this Order. This is required regardless of whether Respondent is employed in nursing.

8. Twelve Step Meetings

Respondent shall attend and participate in a minimum of three (3) Twelve Step meetings per week for the duration of this Order. The Respondent shall submit meeting attendance verification sheets monthly, according to schedule, on the Board-approved form, for the duration of the Order period. It is required that Respondent have a sponsor during the period of this Order. If there is a sponsor, the Board should be provided sufficient information as how to contact this individual. This is required regardless of whether Respondent is employed in nursing.

9. Self-Report

Respondent shall submit a written status report to the Board on a Board-approved form. This is to be submitted on a monthly basis, according to schedule, and must contain a self-assessment of current status. This report is required regardless of whether Respondent is employed in nursing.

10. Primary Physician – Drug Use Exception

The Respondent will have only one primary physician/group during the period of this Order. The primary physician must refer to any other physician, except in a documented emergency. All mood-altering medications or medications containing a mood-altering substance must be prescribed to Respondent by this primary physician for a bona fide medical condition, or if prescribed by the referred physician, must be immediately reported in writing by the Respondent to the primary physician with a copy to the Board. Respondent must notify the Board of the name, address, and telephone number of the primary physician within ten (10) days of the effective date of this Order and within ten (10) days in the case of a new physician. Respondent shall cause any and all prescriptions to be verified to the Board by the prescribing practitioner on a Board-provided form at the time of the issuance of a prescription and must also provide verification of all medications prescribed prior to the Respondent's Board Order. No prescription over twelve (12) months old should be taken without an updated prescription verification. The Board or its designee may, at any time, request the practitioner to document the continued need for

prescribed medications. Respondent shall keep a written record of medications taken, including over-the-counter drugs, and produce such record upon request by the Board. This is required regardless of whether Respondent is employed in nursing.

11. **Dentist – Drug Use Exception**

The Respondent will have only one dentist during the period of this Order. The primary dentist must refer to any other dentist or dental specialist, except in a documented emergency. All mood-altering medications or medications containing a mood-altering substance must be prescribed to Respondent by this primary dentist for a bona fide dental condition, or if prescribed by a referred dentist, must be immediately reported in writing by the Respondent to the primary dentist with a copy to the Board. Respondent must notify the Board of the name, address, and telephone number of the primary dentist within ten (10) days of the effective date of this Order. Respondent shall cause any and all prescriptions to be verified to the Board by the prescribing dentist on a Board-provided form at the time of the issuance of a prescription and must also provide verification of all medications prescribed prior to the Respondent's Board Order. No prescription over twelve (12) months old should be taken without an updated prescription verification. The Board or its designee may, at any time, request the practitioner to document the continued need for prescribed medications. Respondent shall keep a written record of medications taken, including over-the-counter drugs, and produce such record upon request by the Board. This is required regardless of whether Respondent is employed in nursing.

12. **Abstain from Alcohol Use**

Respondent shall abstain completely from the use of any substance containing alcohol.

13. **Abstain from Drug Use**

Respondent shall abstain completely from the non-prescribed use or possession of controlled substances as defined in the Alabama Uniform Controlled Substances Act, illegal drugs as defined by law, mood-altering substances, or any drugs requiring a prescription (legend)

except as provided for in this Order.

14. Drug Screening

Respondent shall participate as directed in a Board-acceptable program for random drug testing. The drug screen will be a Board-approved drug screen and may include additional chemicals as designated by the Board or its designee. A minimum of one (1) random testing per month shall be done and may be required more frequently as requested by the Board or its designee. Further, the Board or its designee may at any time require the Respondent to undergo additional drug screening of a type specified by the Board, including hair testing, to ensure that the Respondent is free of chemical substances. Refusal to provide a specimen suitable for testing within the requested time frame constitutes a violation of this Order and grounds for disciplinary action. Respondent waives any argument as to chain-of-custody of the sample or validity/accuracy of its testing regarding any positive screen received by the Board from an approved testing facility. The report of a positive drug screen which is not a result of documented, prescribed medications as provided for herein shall be considered a violation of this Order. This is required regardless of whether Respondent is employed in nursing.

15. Employment - Monitoring

Respondent shall practice only under the on-site monitoring of a Board-approved licensed health professional in good standing with their professional regulatory body. The employment monitor is not required to be on the same unit or ward as Respondent but should be on site and readily available to provide assistance and intervention in the event the Respondent appears impaired or otherwise unable to safely practice. The Respondent shall work only regularly assigned, identified, and predetermined units. The on-site monitor shall be primarily one (1) person. The Respondent shall not be self-employed or contract for services.

16. Employment-Increased Autonomy

Following two (2) years of satisfactory compliance with stipulations, Respondent may request to work areas which have limited supervision. If such is granted, said employment will be

with specified conditions as set forth by the Board. In no event may Respondent engage in unsupervised practice without prior written authorization from the Board or its designee.

17. **Restricted Employment**

Respondent shall not work for a nursing registry, traveling nurse agency, nursing float pool, hospice, home health agency, or temporary employment agency without prior written authorization from the Board or its designee.

18. **Employment-Supervision Restriction**

Respondent shall not be employed as a supervising nurse.

19. **Employment - Access to Drugs**

Respondent shall not administer or have access to controlled substance medications for a minimum of six (6) months of employment, and shall not have access to or administer controlled substance medications until written permission is received from the Board stating this stipulation no longer applies. Respondent shall work in nursing a minimum of six (6) months without this restriction prior to completing the Order.

20. **Employment - Hours of Practice**

Respondent shall not work more than eighty (80) hours in a two (2) week period without prior written authorization from the Board or its designee.

21. **Employment - Notification**

Respondent shall provide all health care employers, collaborative and covering physicians (if CRNP/CNM) and schools of nursing with a copy of this Order and cause each to acknowledge to the Board that a copy of this Order has been provided to them. Said notification shall be received by the Board no later than ten (10) days after the effective date of this Order or within ten (10) days of Respondent's employment or advanced practice approval or entry into school and must be on the Board-provided form.

22. **Employment - Change in Status**

Respondent shall not accept or change employment without prior written notification to the Board. Said notification must include the name and number of the person who will be Respondent's supervisor.

23. **Employment - Evaluation of Performance**

Respondent shall cause the employer to provide to the Board, on a Board-approved form, a written evaluation of Respondent's nursing performance. Such reports are due quarterly, according to schedule. The receipt of an unfavorable report may be considered to be a violation of this Order. If Respondent is not employed as a nurse, Respondent is required to inform the Board of employment status in the monthly self-report.

24. **Not Employed in Nursing**

In order to complete the terms of this Order, the Respondent must have been employed as a practicing nurse for a minimum period of eighteen (18) months. During periods of employment in fields other than nursing, Respondent is not relieved from compliance with all other terms and conditions of this Order.

25. **Alabama Licensure Status**

Respondent must maintain a current license at all times during the period of probation. If for any reason Respondent allows the nursing license to lapse/expire, such may be cause for disciplinary action.

26. **Notification of Board**

If Respondent is arrested by any law enforcement agency or is admitted as a patient to any institution in this state or elsewhere for treatment regarding the abuse of or dependence on any chemical substance, or for treatment for any emotional or psychological disorder, Respondent shall cause the Board to be notified immediately. Respondent also shall immediately report to the Board any relapse as well as any disciplinary action issued by an employer. Should Respondent

test positive on any drug screen conducted by an employer, an employee assistance program, court referral program or other entity, the Respondent shall immediately report such to the Board.

27. **Change of Address**

Respondent shall immediately notify the Board, in writing, of any change of address.

28. **Relocation**

The Respondent must notify the Board of pending relocation outside the State of Alabama. If Respondent plans to relocate to another state, Respondent must inform that state's board of nursing as to licensure status and may request the Alabama Board to transfer monitoring to the other state. If monitored by another state, Respondent must successfully complete all requirements of the Board Order of the other jurisdiction in order to fulfill the terms of this Order. Respondent must submit to the Alabama Board a copy of the Order from the other state and official notification of successful completion or unsuccessful termination thereof. The Board retains the right to withdraw approval for out-of-state monitoring if circumstances indicate that such is appropriate.

29. **Personal Interview**

Respondent shall appear in person for interviews at the request of the Board or Board designee.

30. **Obey the Laws**

Respondent shall refrain from violation of any federal, state or local law or rule or Order of the Board. A conviction on any criminal charge pending at the time of the signing of this Order may result in further disciplinary action. Any arrest subsequent to the signing of this Order may result in further disciplinary action.

31. **Release of Records and Information**

Respondent hereby authorizes the Board of Nursing to submit information and all records necessary to ensure compliance with the stipulations of this Order and public safety. This includes communication with Respondent's employer (existing and prospective) and members of

Respondent's treatment team regarding noncompliance and/or possible relapse. Respondent also agrees to execute all appropriate release of information forms so as to allow all treatment providers, healthcare providers, employers and all other necessary persons to inform the Board, in writing, of Respondent's status and progress.

32. **Violation**

Any deviation from the requirements of this Order without the written consent of the Board shall constitute a violation of this Order and will be cause for disciplinary action.

33. **Subsequent Practice Act Violation**

Should supplemental cause for disciplinary action arise during the period of this Order such is cause for disciplinary action.

34. **Fraudulent Acts During Period of Order**

Submission of fraudulent documents or reports or misrepresentation of facts relating to the terms and conditions stated herein shall constitute a violation of this Order.

35. **Termination of Order**

This Order shall terminate only upon receipt of documents to satisfy all terms and conditions of this Order, including receipt of official court records documenting successful completion of court-ordered probation, pretrial diversionary-type program, drug court, etc., where applicable. This period of probation will not terminate until notification by the Board to Respondent in writing that all terms and conditions have been met and the probation has been completed.

36. **Public Information**

This Order is public information. All disciplinary actions of the Board will be reported to all required data banks.

37. **Effective Date**

The effective date of this Order shall be the documented date of service or attempted service by certified mail or personal service.

38. Final Order

This Order is subject to full Board consideration and acceptance before it shall be final.

EXECUTED on this the 6th day of May 2020.

Steven Wade Swihart
STEVEN WADE SWIHART

APPROVED AND ACCEPTED by the ALABAMA BOARD OF NURSING on this the 16th
day of July 2010.

N. Genell Lee
N. GENELL LEE, RN, MSN, JD
EXECUTIVE OFFICER
ALABAMA BOARD OF NURSING